**Home Health Care Payment Policy**

The following payment policy applies to Tufts Health Plan contracted home health care providers.

This policy applies to Commercial¹ and Tufts Health Freedom Plan products. For Tufts Medicare Preferred HMO, click here.

**Note:** Audit and disclaimer information is located at the end of this document.

**POLICY**

Tufts Health Plan covers medically necessary home health care services, as described below.

**GENERAL BENEFIT INFORMATION²**

Services and subsequent payment are based on the member’s benefit plan document. Providers and their office staff should use self-service channels to verify effective dates and copayments for members prior to initiating services. Refer to the Electronic Services section of our website for our self-service channel options.

Benefit specifics should be verified prior to initiating services by logging on to our website or by contacting Provider Services.

**MEMBER RESPONSIBILITY**

Copayments, deductible and/or coinsurance may be applied pursuant to the member’s benefit plan document.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible amount until the claim has processed so that the appropriate member responsibility can be determined. Both the provider’s Explanation of Payment (EOP) and the Electronic Remittance Advice (ERA) will reflect the member’s responsibility amount.

**Note:** Tufts Health Plan will not allow the use of a so-called "waiver" to circumvent or override the provider’s obligations under the applicable participation agreement with regard to services covered under the member's plan. By way of illustration and not limitation, the waiver is of no validity when applied to missed filing deadlines, provider's authorization requirements and attempts to collect payments other than applicable copayments, coinsurance or deductibles.

**AUTHORIZATION REQUIREMENTS**

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Refer to the Guidelines section in the Resource Center on our website for a list of procedures, services and items that require prior authorization. Refer to the CareLinkSM Prior Authorization List for a list of procedures, services and items requiring prior authorization for CareLink members.

For authorization information and/or prior authorization requirements for members using the PHCS (also known as MultiPlan) network, contact American Health Holding.

**Services Requiring Prior Authorization**

While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Refer to the Authorization Policy for specific inpatient notification, referral and authorization requirements. Referrals are not required for home health care services; however, a provider’s order is required.

The home health care provider is responsible for verifying a member’s eligibility and benefit coverage before treatment services are rendered. If services are requested after hours, verification and

¹ Commercial products include HMO, POS, PPO & CareLinkSM when Tufts Health Plan is Primary Administrator.
² Eligibility may be subject to retroactive reporting of disenrollment.
authorization must be obtained on the next business day. Request for continued authorization of services are the responsibility of the provider and must be made at least 2 business days prior to the end of the current authorization. Refer to the Home Care Prior Authorization Review Workflow below for more information.

**Home Care Prior Authorization Review Workflow**

**Initial Evaluation Visit**
The initial skilled nursing (SN), and/or physical therapy (PT) home care assessment/evaluation visit does not require prior authorization for Tufts Health Plan members.

Speech therapy, occupational therapy and social work only require prior authorization for the initial evaluation when provided independently and not in conjunction with physical therapy or skilled nursing visits.

**Post Evaluation Visits** (All visits require prior authorization)
To request prior authorization, the Tufts Health Plan network home care provider must:
- Complete an initial evaluation visit (provider order is required)
- Document the initial evaluation results, evidence of homebound status, individualized member goals and plan of care on the Universal Health Plan/Home Health Authorization Form (UHHA). For information on how to fill out the UHHA form, refer to the Guidelines for Completing the UHHA Form. All fields must be thoroughly completed on the UHHA form.
- Include each discipline and the number of visits needed and duration on the UHHA form
- Fax legible UHHA form to Tufts Health Plan Precertification Department at #617.972.9409 within 2 business days of the evaluation visit.

To find the Delegated Care Manager responsible for care management and authorization reviews for HMO members, refer to the Commercial Delegated Care Manager Assignment List.

In certain circumstances, Tufts Health Plan may authorize coverage of an initial 30 day period. Based on Tufts Health Plan data, it is anticipated that goals can usually be met in 30 days or less.

**Subsequent/Ongoing Visits**
For ongoing requests beyond the initial coverage period, documentation must be submitted on the UHHA with the following information:
- For each discipline, clearly identify which goals were met and not met
- The progress made toward the unmet goals
- Any barriers identified that will impact the member’s ability to meet the unmet goals
- The plan to address those barriers, including follow up with the attending provider
- Anticipated number of visits needed to meet goals
- Documentation of the plan is required.

To prevent a gap in coverage all subsequent/ongoing requests must be submitted at least 2 business days prior to the coverage period end date (or before last visit, whichever is sooner).

**Lack of Information**
UHHA forms that are not filled out completely, including defined medical goals and plan of care will be rejected for lack of information. In rare circumstances, you may be asked to provide the information in a shorter timeframe. Tufts Health Plan reserves the right to deny coverage of services when the provider fails to submit required clinical information.

**The Tufts Health Plan Precertification Department will:**
- Review the request and make a determination within 2 business days of receipt
  - Approvals are faxed back to the provider (within 2 business days of request)
  - Pending requests are forwarded for medical director (MD) review/determination
  - MD denials are communicated via telephone and a letter is mailed back to the provider within 1 business day of communication.

Refer to the CareLink™ Prior Authorization List for a list of procedures, services and items requiring prior authorization for CareLink members.

For a complete description of Tufts Health Plan’s Commercial authorization requirements, refer to the Authorization section within the Tufts Health Plan Commercial Provider Manual.
**Prenatal Homemaker Services- Tufts Health Freedom Plan Products Only**

Tufts Health Freedom Plan covers medically necessary prenatal homemaker services when a woman is confined to bedrest or her activities of daily living are otherwise restricted on the recommendation of her attending health care provider. Homemaker services are also covered postpartum as determined by the attending health care provider.

**BILLING INSTRUCTIONS**

- Submit the most updated industry standard codes.
- Submit a modifier, when applicable, with the corresponding CPT and/or HCPCS procedure code(s).
- For more information regarding modifiers refer to the Modifier Payment Policy.
- Submit only the procedure codes listed in the table as described in the Provider Agreement.
- Submit only the Home Health Care Revenue Codes 0550-0599 when billing in 837I format or on a UB-04 Form only; Revenue Codes may not impact compensation and are used to determine place of service only.
- Submit a corresponding CPT and/or HCPCS code for every Revenue Code submitted. Tufts Health Plan acknowledges that certain Revenue Codes may not have a corresponding CPT and/or HCPCS code; however, in all cases the provider is encouraged to find a procedure code for every Revenue Code.

**Note:** Annually and quarterly, HIPAA medical code sets undergo revision by CMS, AMA and CCI. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-CM diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes.

To view the status of submitted authorizations and claims, log on to our secure [website](#).

**EDI Claim Submitter Information**

- Submit claims in appropriate HIPAA compliant 837 format. Claims billed electronically with non-standard codes will reject.

**Paper Claim Submitter Information**

- Submit claims on an official claim form for professional services. Claims billed with non-standard codes will deny.
- All paper claims must be submitted on standard red claim forms. Black and white versions of these forms, including photocopied and faxed versions, will not be accepted and will be returned with a request to submit on the proper claim form.
- Submitted forms deemed incomplete will be rejected and returned to the submitter. The rejected claim and a letter stating the reason for rejection will be returned to the submitter, and a new claim with the required information must be resubmitted for processing.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151</td>
<td>Services of Physical therapist in home health setting, each 15 minutes*</td>
</tr>
<tr>
<td>G0152</td>
<td>Services of Occupational Therapist in home health setting, each 15 minutes*</td>
</tr>
<tr>
<td>G0153</td>
<td>Services of Speech and Language Pathologist in home health setting, each 15 minutes*</td>
</tr>
<tr>
<td>G0155</td>
<td>Services of Clinical Social Worker in home health setting, each 15 minutes*</td>
</tr>
<tr>
<td>G0156</td>
<td>Services of Home Health Aide in home setting, each 15 minutes</td>
</tr>
<tr>
<td>G0157</td>
<td>Services performed by a qualified physical therapy assistant in the home health setting, each 15 minutes</td>
</tr>
<tr>
<td>G0158</td>
<td>Services performed by a qualified occupational therapy assistant in the home health setting, each 15 minutes</td>
</tr>
<tr>
<td>G0162</td>
<td>Skilled services by a registered nurse (RN) in the delivery of management and evaluation of the plan care, each 15 minutes</td>
</tr>
<tr>
<td>G0163</td>
<td>Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes</td>
</tr>
</tbody>
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3 Applies to Tufts Health Freedom Plan Products only, per N.H. RSA 417-D-a.
4 HIPAA medical code sets include HCPCS, CPT Procedure and ICD-CM diagnosis codes.

**Revised 01/2016**

Home Health Care Payment Policy
Procedure Code | Description |
---|---|
G0299 | Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes |
G0300 | Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice setting, each 15 minutes |
S9470 | Nutritional Counseling, dietitian visit |
S9123 | RN Private Duty Nursing - Nursing Care, in the home; by a Registered Nurse, per hour |
S9124 | LPN Private Duty Nursing- Nursing care, in the home; by licensed practical nurse, per hour |
99501 | Early Maternity Discharge Visit or Maternal Child Home Visit- Home visit for post natal assessment and follow-up care (one visit only) |
99211 | Office or other outpatient visits for Evaluation and Management. A visit is up to 30 minutes |
S5130 | Homemaker service, NOS; per 15 minutes |

Note: Asterisk (*) indicates: A visit is up to 2 hours. An authorized visit should be billed as 8 units.

Home Health Aide visits should be billed in increments of 15 minutes. For example, a one-hour Home Health Aide visit will be billed for 4 units.

Clarification of Home Health Services
1. Office visits are allowed at the home health care office for simple medical procedures when no other option is available. Situations that qualify for payment of office visits at the home health care agency include:
   - Services that require skilled intervention that member/caregiver are unable to provide.
   - Member is not homebound.
   - Member has no other available option for provision of skilled service.
   - No other services are being provided in the home by the home health care agency.

2. Early maternity discharge and maternal child home visits do not require prior authorization. Coverage is for either one of the two home visits listed below. Any additional visits for these services would require prior authorization.
   a. Early maternity discharge visits must be made within 48 hours of discharge from the hospital. This visit should be billed **one time only** under the mother’s name and is subject to the limitations of the applicable State mandate.
   b. Maternal child home visits must be made within 48 hours of discharge from the hospital. This visit should be billed **one time only** under the mother’s name. It is the responsibility of the provider to verify that a member is covered for the maternal child home visit benefit prior to performing the visit.

3. All home health care services include certain incidental supplies. Commonly-used incidental supplies that are not separately reimbursed include, but are not limited to, the following incidental supplies:
   - Adhesive Bandage Strips
   - Blood Pressure Cuff
   - Cartridge for Finger stick Clotting Time
   - Clean Gowns
   - Eye Shields
   - Non-Sterile Gloves
   - Scissors
   - Sterile Q-Tips
   - Steristrips
   - Routine dressings
   - Stethoscope
   - Suture Removal Kits
   - Tape
   - Tongue Depressors

Note: All other medical supplies, such as for complex wound care or DME, must be obtained from a Tufts Health Plan participating DME provider and may require prior authorization by the Tufts Health Plan.

COMPENSATION/REIMBURSEMENT INFORMATION
Providers are compensated according to the Tufts Health Plan network contracted rates regardless of the address where the service is rendered. Claims are subject to payment edits that are updated at regular intervals and generally based on Centers for Medicare & Medicaid Services (CMS), specialty society guidelines, drug manufacturers’ package label inserts and the National Correct Coding Initiative (CCI).
Procedure Code Guidelines
Tufts Health Plan will not compensate for inappropriately-coded services, based on CPT/HCPCS Procedure Code Guidelines.

Explanation of Payment (EOP)
The EOP provides information on the status of the claim(s) submitted to Tufts Health Plan. The EOP indicates status of claims payments, denials and pending claims.

Electronic Remittance Advice (ERA)
The HIPAA compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

ADDITIONAL RESOURCES
Durable Medical Equipment Payment Policy

DOCUMENT HISTORY
- January 2016: Added S2130 for Tufts Health Freedom Plan products, added procedures codes G0299 and G0300 and deleted procedure code G0154 as it was end dated on December 31, 2015.
- September 2015: Template conversion, template updates
- January 2014: Review process clarified, template updates
- September 2013: Template conversion
- May 2103: Policy reviewed, minor content changes, template updates
- January 2013: Template updates.
- April 2012: Template updates.
- March 2012: Updated CareLink disclaimer language
- July 2010: Reviewed document for clarity
- October 2009: Removed old home care prior authorization workflow and incorporated the new workflow effective October 1, 2009.
- August 2009: Added link to new home care prior authorization workflow, effective October 1, 2009.
- February 2008: Added Home Care Prior Authorization Review Workflow and revised general benefit information with self-service channels information.
- March 2000: Policy created.

AUDIT AND DISCLAIMER INFORMATION
Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options, Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink for providers in the Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members.